C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.i.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

February 27, 2009

Kathy Prophet, Administrator Preferred Community Homes—Bedford 7091 West Emerald Street Boise, Idaho 83704

RE: Preferred Community Homes—Bedford, provider #13G039

Dear Ms. Prophet:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Preferred Community Homes—Bedford, on February 18, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
- 2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- 5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Kathy Prophet, Administrator February 27, 2009 Page 2 of 2

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by March 12, 2009, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

TOM MROZ Health Facility Surveyor

Facility Fire Safety and Construction Program

TM/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/23/2009 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|---------------------|---|--|-------------------------------|--|
| 13G039 | | B. WING | B. WING | | 02/18/2009 | | | |
| NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - BEDFOR STREET ADDRESS, CITY, STATE, ZIP CODE 398 EDGAR COURT MERIDIAN, ID 83642 | | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| K 000 | INITIAL COMMEN | TS | | K 000 | | | | |
| | building. It is Type sprinklered through attic by a 13 D extil Response heads. alarm/smoke detection dult in January of ICF/MR beds. The following defic facility during the a conducted on Februs surveyed under the Edition, Chapter 33 Care Occupancies | veyor | and is age and with Quick fire cility was for 8 the above y survey facility was E, 2000 I Board & ion | | | | | |
| K0152 | 483.470(j)(1)(i) LIF STANDARD | FE SAFETY CODE | | K0152 | | | | |
| | quarterly for each s varied conditions to (i) Ensure that all p trained to perform (ii) Ensure that all p familiar with the us and disaster plans | personnel on all shifts assigned tasks; personnel on all shifts e of the facility's ementand procedures. | l under are are | | | | | |
| I ADODATO | 1 ., | st - ite clients during at le VIDER/SUPPLIER REPRESI | | GNATURF | TITLE | | (X6) DATE | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/23/2009 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G039 | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 | | | (X3) DATE SURVEY COMPLETED | |
|---|--|-------------------------|--|---|--|-----------------------------------|-------------------------------|--|
| | | B. WING | | | 02/18/2009 | | | |
| | ROVIDER OR SUPPLIER RED COMMUNITY | HOMES - BEDFOR | 398 ED | RESS, CITY, S GAR COUI IAN, ID 83 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| K0152 | Continued From page 1 drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. | | K0152 | | | | | |
| | Based on record redetermined the facility were conduct of 6 individuals (Inche facility. This refacility and staff no individuals' respons The findings included. 1. During a review on 2/18/09, the following the third quarter (Jagrave-yard shift (1) - There was no even the third quarter (Jagrave-yard shift (1 | of the facility's evacu | iew, it was evacuation is shift for 6 iding in al for the mine em areas. uation drills ted during ber) for the). | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/23/2009 FORM APPROVED OMB NO. 0938-0391

| CENTER | S FOR MEDICARE | & MEDICAID SERV | CES | | | OMB NO. | 0938-0391 | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER AND PLAN OF CORRECTION IDENTIFICATION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 | | | (X3) DATE SURVEY COMPLETED 02/18/2009 | |
| | | 13G039 | 13G039 | | B. WING | | | |
| | ROVIDER OR SUPPLIER | | i | | TATE, ZIP CODE | | | |
| PREFER | RED COMMUNITY | HOMES - BEDFOR | | GAR COUI DIAN, ID 830 | | | | |
| WA 15 | CHARAADY CT | ATEMENT OF DEFICIENCIE | | ID ID | | N OF CORRECTION | (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEEDED B LSC IDENTIFYING INFORM | Y FULL | PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | E ACTION SHOULD BE TO THE APPROPRIATE CIENCY) | COMPLÉTION DATE | |
| K0152 | When asked during 10:53 a.m., the Hol could not be found had not been comp | g an interview on 2/18 me Manager stated t and she was unsure | he drills why they drills were | K0152 | | | | |
| | | | | | | | | |

PRINTED: 02/23/2009

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING_ 02/18/2009 13G039 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 398 EDGAR COURT PREFERRED COMMUNITY HOMES - BEDFORD MERIDIAN, ID 83642 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG **DEFICIENCY**) M 000 16.03.11 Inital Comments M 000 The facility is a single story, residential type building. It is Type V(000) construction and is sprinklered throughout except in the garage and attic by a 13 D extinguishment system with Quick Response heads. There is a complete fire alarm/smoke detection system. The facility was built in January of 1996 and is licensed for 8 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on February 18, 2009. The facility was surveyed under the LIFE SAFETY CODE, 1976 Edition, "Lodging and Rooming Houses " contained in Chapter 11, " Lodging and Rooming House Occupancies " and applicable provisions of Chapters 01 through 07, Chapter 17 and Appendices A and B of the Life

MM309

Refer to federal deficiencies listed on the CMS 2567 form.

This Rule is not met as evidenced by:

Fire/Life Safety & Construction Program

16.03.11.110 Fire and Life Safety Standards

Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities.

TITLE

(X6) DATE

Safety Code, Impractical Evacuation Capability in

The annual fire/life safety survey was conducted

accordance with IDAPA 16.03.11.

by:

Tom Mroz

Health Facility Surveyor

K152 Evacuation Drills

MM309

PRINTED: 02/23/2009 FORM APPROVED

Bureau of Facility Standards (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION 02 A. BUILDING B. WING __ 02/18/2009 13G039 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **398 EDGAR COURT** PREFERRED COMMUNITY HOMES - BEDFORD MERIDIAN, ID 83642 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) MM309 Continued From Page 1 MM309

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

Printed: 02/23/2009 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 B. WING 02/18/2009 13G039 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 398 EDGAR COURT PREFERRED COMMUNITY HOMES - BEDFOR MERIDIAN, ID 83642 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Preparation and implementation of this plan of corrections does not constitute K 000 K 000 INITIAL COMMENTS admission or agreement by Bedford with the facts, findings, or other The facility is a single story, residential type statements as alleged by the State building. It is Type V(000) construction and is agency dated February 18, 2009. sprinklered throughout except in the garage and Submission of this plan of correction is attic by a 13 D extinguishment system with Quick required by law and does not evidence Response heads. There is a complete fire the truth of any of the findings as stated alarm/smoke detection system. The facility was by the survey agency. Bedford built in January of 1996 and is licensed for 8 specifically reserves the right to move to strike or exclude this document as ICF/MR beds. evidence in any civil, criminal or The following deficiencies were cited at the above administrative action. facility during the annual Fire/Life Safety survey conducted on February 18, 2009. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & K0 152 483.470(j)(1)(i) LIFE SAFETY Care Occupancies, Impractical Evacuation CODE STANDARDS Capability in accordance with 42 CFR 483.470 (j). The facility will ensure that evacuation The Survey was conducted by: drills will be completed at least quarterly on all shifts for each shift of Tom Mroz personnel. Staff training will be Health Facility Surveyor implemented on fire drills and the Fire/Life Safety and Construction regulations that must be followed for this facility. A monthly review of evacuation drills will be completed by the AQMRP of K0152 K0152 483.470(j)(1)(i) LIFE SAFETY CODE the facility. **STANDARD** Person Responsible: AQMRP, RSC Completion date: 3-23-09 (1) The facility holds evacuation drills at least Monitoring: Monthly quarterly for each shift of personnel and under varied conditions to -RECEIVED (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are MAR 6 5 2009 familiar with the use of the facility's emergency and disaster plans and procedures. FACILITY STANDARDS (2) The facility must -(i) Actually evacuate clients during at least one (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIED REPRESENTATIVE'S SIGNATURE

(X2) MULTIPLE CONSTRUCTION

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Printed: 02/23/2009 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 B. WING _ 02/18/2009 13G039 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - BEDFOR 398 EDGAR COURT MERIDIAN, ID 83642 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K0152 K0152 Continued From page 1 drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. This Standard is not met as evidenced by:

This Standard is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include:

- 1. During a review of the facility's evacuation drills on 2/18/09, the following was noted:
- There was no evacuation drill completed during the third quarter (July, August, September) for the grave-yard shift (11:00 p.m. - 7:00 a.m.).
- There was no evacuation drill completed during the third quarter for the P.M. shift (3:00 11:00 p.m.).

DÉPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 02/23/2009 FORM APPROVED MB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 | | (X3) DATE SI COMPLE | (X3) DATE SURVEY COMPLETED 02/18/2009 | |
| 13G039 | | | B, WING | | - 02/1 | | | |
| | ROVIDER OR SUPPLIER RED COMMUNITY | HOMES - BEDFOR | 398 ED | GAR COUF | | | | |
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| K0152 | When asked during 10:53 a.m., the Ho could not be found had not been comp The facility failed to | g an interview on 2/1 me Manager stated t and she was unsure | the drills why they drills were | K0152 | | | | |
| | | | | | | | | |

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 13G039 02/18/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 398 EDGAR COURT PREFERRED COMMUNITY HOMES - BEDFORD MERIDIAN, ID 83642 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) M 000 16.03.11 Inital Comments M 000 Preparation and implementation of this plan of corrections does not constitute The facility is a single story, residential type admission or agreement by Bedford building. It is Type V(000) construction and is with the facts, findings, or other sprinklered throughout except in the garage and statements as alleged by the State attic by a 13 D extinguishment system with Quick agency dated February 18, 2009. Response heads. There is a complete fire Submission of this plan of correction is alarm/smoke detection system. The facility was required by law and does not evidence built in January of 1996 and is licensed for 8 the truth of any of the findings as stated ICF/MR beds. by the survey agency. Bedford specifically reserves the right to move The following deficiencies were cited at the to strike or exclude this document as above facility during the annual Fire/Life Safety evidence in any civil, criminal or survey conducted on February 18, 2009. The administrative action. facility was surveyed under the LIFE SAFETY CODE, 1976 Edition, "Lodging and Rooming Houses " contained in Chapter 11, " Lodging and Rooming House Occupancies " and applicable provisions of Chapters 01 through 07, Chapter 17 and Appendices A and B of the Life Safety Code, Impractical Evacuation Capability in accordance with IDAPA 16.03.11. RECEIVED The annual fire/life safety survey was conducted by: MAR 0.5 2009 Tom Mroz Health Facility Surveyor FACILITY STANDARDS Fire/Life Safety & Construction Program MM309 16.03.11.110 Fire and Life Safety Standards MM309 Buildings on the premises used as facilities must MM309 16.03.11.110 Fire and Life meet all the requirements of local, state and national codes concerning fire and life safety Safety Standards standards that are applicable to ICF/MR facilities. Refer to K0152 This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. K152 Evacuation Drills LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

021199

Bureau of Facility Standards

STATE FORM

PRINTED: 02/23/2009 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING _ 13G039 02/18/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **398 EDGAR COURT** PREFERRED COMMUNITY HOMES - BEDFORD MERIDIAN, ID 83642 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) Continued From Page 1 MM309 MM309

Bureau of Facility Standards